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ABSTRACT

This needs assessment study of mental health needs of the elderly in Pennsylvania used a three-part approach. These parts were a review of existing data sources, an extensive key informant study, and a review of service delivery models. A recent study found a prevalence rate for mental illness in the elderly of 12.8%, more than 5% lower than the rate for the general population. This study also found that the elderly made fewer mental health visits to professionals than did younger adults. In a key informant survey, mental health and elderly services administrators were interviewed. Results of this survey showed the following: (1) loneliness, social isolation, and physical ailments were the most common risk factors for mental illness; (2) depression was the most common mental health problem; (3) the most important barriers to mental health services were stigma and the idea that problems were not mental health problems; (4) medical care and advice were the most common types of help received by needy elderly; and (5) refusal or resistance to receiving mental health services was the most important reason for keeping elderly in need from receiving service. Demonstration mental health service programs perceived lack of coordination between service providers and transportation as less important barriers to receiving mental health services than did non-demonstration mental health services providers. (ABL)

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# A STATEWIDE KEY INFORMANT SURVEY AND SOCIAL INDICATORS ANALYSIS

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Pennsylvania's Needs Assessment

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# A STATEWIDE KEY INFORMANT SURVEY AND SOCIAL INDICATORS ANALYSIS

## Overview of Needs Assessment Process

The needs assessment described in this paper took a three part approach to studying the mental health needs of the elderly in Pennsylvania. First we used a variety of existing data sources for general information about the problem as well as data specifically about Pennsylvania. This included a review of the epidemiological literature and a compilation of rates under treatment data. Second, we conducted an extensive key informant study. These two parts constituted a formal analysis of the needs of the elderly. For the final part we conducted a review of models of service delivery for the elderly nationwide and of the demonstration programs in Pennsylvania. Thus, we analyzed needs at the same time we analyzed possible solutions, so that both sides could be included in the policy making process. I will first discuss the data we gathered from existing sources and then I will discuss the key informant study. Lee VandeCreek will discuss the models of service delivery and the recommendations based on our complete data. The data reported here represent the most important findings from a much larger report. That report is available from the authors (VandeCreek and Fleischer, 1985).

## Epidemiological Data

Needless to say, we made no attempt to conduct a study of the epidemiology of mental illness in the elderly ourselves. However, we did review the literature in regard to this. In general, the

literature on mental health epidemiology is sparse. However, it is even sparser for the mental health problems of the elderly. We found surprisingly few studies that addressed this issue. Worse, what we found gave us a rather remarkable range to work with. The best review we could find gave a range of between 18% and 45% of the elderly having experienced a mental health disorder over a six month period (Blazer 1980).

One very recent set of studies, not reviewed by Blazer, is the Epidemiological Catchment Area (ECA) studies (Myers, et al., 1984). While the ECA studies are not yet complete, and far from perfect, they provide some of the best data available from a methodological point of view. The limited data available suggest a 6 month prevalence rate for the elderly of 12.8%, vs. a rate of 18.1% for the general population. I might add however, that there is good reason to believe that the elderly may under-report mental health problems at a rate greater than the general population (Reiffler, Cox, & Hanley, 1981) and that their probable prevalence rate is likely at least as high as that of the general population.

## Rates-under-treatment

There are two main sources of data to report here. The first comes from one of the ECA studies. In addition to looking at epidemiology, the ECA study investigated the treatment received by those who had experienced a mental health problem. The differences between the elderly and the general population are particularly striking. The ECA study reports that 13.3% of the elderly (over 65) with a mental health problem made what they called a "mental health

visit" (i.e. a visit to a professional for any mental health purpose) while 20.9% of those 45-65 with a mental health problem made such a visit. When narrowed to visits to mental health specialists, ECA reports that only 4.5% of those elderly made such a visit as compared to 10.5% of those 45-65. Clearly, the elderly make much less use of mental health services and receive less treatment for their mental health problems.

The other source of data we used was statistics reported by the Pennsylvania Office of Mental Health. They report that 1% of the elderly in Pennsylvania visited a public mental health facility in 1984 vs. 2.3% of those 18-65. They also report that, although the elderly make up 18.2% of PA's population, only 7% of the MH caseload is elderly. Again, this suggests extreme underutilization of services by the elderly.

## Key Informant Study

### Sampling

In order to understand our sampling procedures the reader needs to understand a few things about the structure of Pennsylvania's mental health and aging systems. Mental health services in Pennsylvania are provided under the oversight and funding of a county level officer, the MH/MR Administrator. Within each county there are one or more Base Service Units (BSU). In the sense that the BSU covers a particular territory, it is equivalent to a catchment area. In terms of services, the BSU provides only intake and case management. All other services are provided by some other organizational structure. Most BSUs are housed in a mental health

center with many of the other mental health services. Aging services are provided by Area Agencies on Aging that are all county level organizations. Pennsylvania has 87 Base Service Units. We randomly selected 22 in which we would conduct our Key Informant (KI) study. In addition to these 22, we added 5 BSUs that were providing demonstration projects for the state, giving a total of 27 BSUs in the sample.

In each BSU we determined ahead of time the types of KIs we wished to interview. These were: the MH/MR administrator, the AAA director, the BSU director, a AAA service manager, a senior center director, a visiting nurse, a general hospital social worker, a housing manager, a long term care facility operator, a boarding home operator, a physician, 2 clergy, and 2 local elderly citizens. We got the names of the MH/MR administrator and the AAA director from published lists and used a snowball sampling technique to obtain the rest.

## Data Collection

Two types of questionnaires were used. The MH/MR and AAA administrators were interviewed by telephone using a relatively short (15 minutes) interview schedule consisting of open-ended questions. In each case the administrator was just called and interviewed on the spot or at some later arranged time.

All other KIs were interviewed by telephone using a much longer (45 minutes) interview schedule. Each KI was called and asked to participate. If they agreed, an appointment was made for the interview and the KI was sent a modified version of the interview

schedule for their preview. Of the 407 individuals contacted in this manner, 303 (74%) actually completed the interview.

## Results

The Key Informants. The KIs were apparently the type of people who would be well informed. Their median length of time of living or working in the BSU community was 10.5 years. More than 80% of them knew 25 or more elderly people.

Risk Factors. One issue of concern in the study was factors that are believed to be associated with the risk of mental illness, so called "risk factors." These could be of particular importance in the planning of prevention efforts. We defined 5 commonly cited risk factors for the KIs and asked them to rank these in terms of how frequently the elderly people they knew had experienced them over the past six months. Table 1 shows the mean ranks for all KIs (lower numbers means more important). Loneliness & social isolation and physical ailments were clearly the most common risk factors. We then asked what percent of the elderly people they knew had experienced one or more of the risk factors in the past 6 months. The median response was 50%. Local elderly and housing managers gave the lowest figures, with 39% and 31% respectively. Visiting nurses and AAA service managers knew the most who had experienced risk factors, 70% and 76% respectively.

--Table 1 Here--

Mental Health Problems. We gave the KIs another list of 8 mental health problems that we believe is pretty inclusive of all MH problems experienced by the elderly. The mean ranks for these problems is shown in Table 2. Depression is far and away the most common problem, with Thinking & Memory Disorders a distant second (NOTE: Alzheimer's disease was excluded from our definition of this disorder, although we are unsure how many KIs heeded this exclusion.). The median percent of elderly believed to have experienced a MH problem in the past six months was 40%. Local elderly and housing managers again gave the lowest responses to this question, with 25% and 29% respectively. BSU directors and physicians gave the highest figures, 70% and 60% respectively. This pattern of responses was to be expected given the nature of the elderly populations seen by these groups.

--Table 2 Here--

Barriers to Receiving MH Services. We asked the KIs to rate 12 possible barriers to the elderly making use of MH services. They used a 5 point scale ranging from (1) extremely important to (5) not at all important for their answers. Table 3 shows their mean responses. The most important responses can all be termed cognitive or educational, i.e. stigma, MH problems not being viewed as MH problems are related primarily to attitudes and beliefs.

--Table 3 Here--

Individuals at Risk. One of the unusual things we did in this survey was to ask the KIs to describe up to three individuals they knew who had experienced risk factors over the past six months. The 303 KIs described 692 risk factor cases (2.28 per KI). Table 4 shows the percent of these cases that had experienced each risk factor. Of these, 85% received some kind of help. Table 5 shows the kinds of help they received. Medical care and advice were the most common forms of help. When we asked in each case whether more help was needed, 31% needed more of the same type of help, while 47% needed some other type of help (of these, 47% needed therapy, 24% needed advice).

--Table 4 & 5 Here--

Individuals with Mental Health Problems. In addition to asking the KIs about individuals they knew who had experienced risk factors we also asked them about individuals who had experienced a mental health problem in the past six months. The 303 KIs described 592 mental health cases (1.97 per KI). Table 6 shows the percent of these cases who experienced each mental health problem and the percent for whom each problem was considered the most important. Congruent with the more general reports of the KIs, the most common

problems were depression and thinking/memory disorders. Of these cases, 84% had received some kind of help. Table 7 shows the types of help received by these cases. Medical care, therapy, and advice are the most common forms of help. The need for additional help is similar to that for the risk factors, 33% needed more of the same type of help, while 49% needed some other help (of those, 56% needed therapy, 16% needed advice).

--Tables 6 & 7 Here--

Individual Barriers. In each mental health case where an individual either did not receive a service or needed some service other than that received, we asked why that was, what had kept the elderly person from getting the service that was needed? The most important reason (36% of the cases) was that the individual refused or resisted seeking help. In 14% of the cases there was a belief that mental health problems cannot be treated or that treatment was simply not needed. In 12% lack of cooperation between service providers, primarily lack of referral was the problem. Surprisingly this was not seen as a problem of coordination between the aging and MH systems, rather, it was a problem between MH and the rest of the service delivery universe, e.g. physicians. Family resistence was cited in 11% and lack of services was the problem in 10% of the cases. One possible explanation for the importance of refusal as a barrier could lie in the most frequent diagnostic category these

cases were in, depression. A major symptom of depression is apathy, a refusal to take action. This refusal to seek help could be an important manifestation of the disorder.

Additional Results. We began the study with some expectations about the differences between types of BSUs. We expected that rural BSU would probably provide fewer services and that transportation would be a greater barrier there. While lack of services was perceived as a significantly more important barrier for rural BSUs, that was the only significant difference between types of BSUs. We also had expected, but did not find, any difference based on poverty rate or percent of elderly in the BSU.

Demonstration Programs. We made a special effort to compare the 5 demonstration BSUs with the other 22 on all the data we gathered. Given the nature of the demonstrations we hoped that we would find some impact on coordination and thereby on other aspects not only of service delivery, but of how people perceived the mental health problems of the elderly. As predicted, the demonstration BSU KIs perceived lack of coordination as a less important barrier ($t=2.06$, $df=290$, $p$ .05), however, it was not viewed as particularly important in the non-demonstration BSUs. In addition, transportation (another not very important barrier) was viewed as less important ($t=2.79$, $df=298$, $p$ .01). Intriguing, but unexplained, was the finding that the demonstration BSU KIs reported a median of only 30% of the elderly they knew had experienced a mental health problem, as compared to 48% for the non-demonstration BSUs ($t=3.78$, $df=265$, $p$ .001).

This concludes my discussion of the data gathered in Pennsylvania. Lee VandeCreek will now discuss the study we made of models of service delivery. He will also describe the recommendations we derived from the integration of the two parts of the study.

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TABLE 1
Mean Ranks of Risk Factors

| Risk Factors | Mean Rank |
|---|---|
| Lonliness/Social Isolation | 2.30 |
| Physical Ailments | 2.33 |
| Financial Problems | 3.20 |
| Bereavement | 3.30 |
| Retirement | 3.77 |

TABLE 2
Mean Ranks of Mental Health Problems

| Mental Health Problem | Mean Rank[1] |
|---|---|
| Depression | 2.31 |
| Thinking & Memory | 3.30 |
| Anxiety | 3.74 |
| Excessive Health Worries | 4.11 |
| Sleep Problems | 4.88 |
| Other Mood Disorders | 5.71 |
| Drug and Alcohol | 5.86 |
| Severe Mental Illness | 6.12 |

[1]Lower mean rank = more important

TABLE 3

Barriers to Receiving Mental Health Services[1]

| Barrier | Mean Rating |
|---|---|
| Stigma | 1.9 |
| Problems not MH problems | 1.9 |
| MH problems not serious | 2.3 |
| Elderly not aware of MH services | 2.6 |
| MH services too costly | 2.8 |
| Transportation | 2.9 |
| No special services for elderly | 2.9 |
| MH problems can't be treated | 3.0 |
| Lack coordination between service providers | 3.3 |
| Providers don't like elderly | 3.6 |
| Poor reputation of service providers | 3.6 |
| Lack of services available locally | 3.9 |

[1]Lower mean ranks = more important

TABLE 4

Risk Factors for Risk Factor Cases

| Risk Factor | % Cases Experiencing |
|---|---|
| Physical Problems | 62.6% |
| Loneliness & Social Isolation | 54.4% |
| Bereavement | 35.5% |
| Financial Problems | 35.5% |
| Retirement | 25.7% |

TABLE 5

Services for Risk Factor Cases

| Services | % Receiving Service |
|---|---|
| Medical Care | 35.0% |
| Advice/Support and Referral | 29.7% |
| Professional/Paraprofessional Therapy/Counseling | 12.3% |
| Recreation | 6.9% |
| 24 Hour Supportive Care | 6.0% |
| Homemaker/Meals | 5.1% |
| Financial Help | 3.9% |
| Transportation | 0.4% |
| Education | 0.2% |
| Other | 0.7% |

NOTE: Percentages do not add to 100% due to rounding error

TABLE 6

Mental Health Problems of Mental Health Cases

| Mental Health Problem | % with Problem[1] | % Problem Most Important[2] |
|---|---|---|
| Depression | 53% | 33% |
| Thinking & Memory | 42% | 21% |
| Anxiety | 40% | 11% |
| Excessive Health Worries | 30% | 11% |
| Sleep Problems | 25% | 3% |
| Severe Mental Illness | 18% | 14% |
| Other Mood Disorders | 14% | 4% |
| Drug & Alcohol Abuse | 13% | 7% |

[1] Percentages add to more than 100% due to multiple responses

[2] Percentages do not add to 100% due to rounding error

TABLE 7
Services Received by Mental Health Problem Cases

| Service Received | % Receiving Service |
|---|---|
| Medical Care | 61% |
| Professional/Paraprofessional Therapy/Counseling | 40% |
| Advice/Support & Referral | 34% |
| 24 Hour Supportive Care | 11% |
| Recreation | 8% |
| Homemaker/Meals | 5% |
| Transportation | 1% |
| Education | 1% |
| Financial Help | 1% |
| Other | 1% |

NOTE: Percentages add to more than 100% due to multiple responses